A Roadmap To LTC Delivery

Clearly, the structure of VA long-term care and budget allocations affect the delivery of long-term care services. To assess the role these play in service delivery, the Committee analyzed VA's network structure, as well as how payment for services directs program utilization.

The Network Structure

The Veterans Health Administration (VHA) is part of VA, and is responsible for serving the needs of America's veterans through an integrated healthcare system. The Under Secretary for Health is responsible for the management of the VHA.

In October 1995, the VHA restructured its field and headquarters operations to complement a new vision for the nation's largest integrated healthcare system. The field reorganization included implementation of the Veterans Integrated Service Network (VISN) management structure. This structure decentralizes day-to-day operations while emphasizing pooling and aligning resources with local needs, and improving customer service. The field is organized into 22 geographically distinct VISNs, each managed by a network director, and includes supporting staff (network clinical manager, network finance officer, etc.), advisory staff from the medical centers, and other stakeholders in veteran care (Executive Leadership Council and Management Assistance Council).

Restructuring VHA headquarters also began in October 1995, with a focus on enabling and supporting change in the field to improve quality and efficiency of care. Changes included eliminating certain positions and offices, reorganizing other offices and functions, and establishing new offices of Policy, Planning and Performance; Chief Information Officer; and Employee Education. Support services in headquarters were consolidated into 10 strategic healthcare groups. In addition, the Chief Network Officer became part of the integrated Office of the Under Secretary for Health.

The Funding Mechanism

In April 1997, VA implemented a new system to allocate its $17 billion Congressionally appropriated Medical Care budget to the 22 VISNs. The Veterans Equitable Resource Allocation (VERA) capitation-based system was developed to address historical imbalances in funding across the country and to counter a perception that the previous models were too complex.

The VERA system recognizes geographic differences in labor costs and also makes adjustments for research, education, equipment, and non-recurring maintenance. Shifts in total funds from one network to another also are capped to mitigate against significant single-year reductions.

In general, under capitation systems, management tends to avoid the long-term care population because of the high cost. VERA attempts to balance a simplified allocation approach with the complexities of VA's healthcare system. VERA divides patients into two care groups. Basic Care patients have routine healthcare needs and were funded at a national average price of $2,604 in fiscal year (FY) 1998. Special Care patients have complex healthcare needs and are funded at $36,960 annually. Most long-term care patients are covered under the Special Care rate. Special Care patients represent 38 percent of the resources, yet comprise only 4.3 percent of the workload. Basic Care patients represent 62 percent of the resources and 95.7 percent of the workload.

Unfortunately, the VERA system, in combination with VA management

initiatives to reduce per patient care costs by 30 percent, has unleashed a set of unintended problems for long-term care services. When VERA patient care rates are compared to average program costs (the average yearly cost of caring for a patient in a program), long-term care does not appear to be reimbursed at full cost. Using actual figures, the Special Care patient rate of $36,960 covers the cost of the average long-term care patient ($36,398). However, management often compares the Special Care patient rate of $36,960 to program costs, which was $85,884 per year for VA nursing home (VANH) patients and $48,946 per year for community nursing home (CNH) patients in FY 1997. When this comparison is made, long-term care services appear too expensive. In reaction to this cost differential, and/or in efforts to reduce average costs in general, local management, in some cases, has reduced access to nursing home care.

Implications

The network structure does not lend itself to meeting national goals or implementing a national strategy for long-term care services. In addition, the VERA system is perceived to underfund many long-term services, creating a tendency to limit expenditures for such services. In combination with selected management initiatives to lower per patient costs, these factors create powerful disincentives to provide long-term care, particularly nursing home care.

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- VA should maximize network flexibility in developing and restructuring its long-term care services within broad national policies.

- VA must create a series of financial incentives and performance measures to ensure that adequate access to long-term care services is provided to veterans.